

## South Middleton School District Registration Form

TODAY'S DATE: \_\_\_\_\_

School:  W.G. Rice Elementary  Iron Forge Educational Center  Yellow Breeches Middle School  Boiling Springs High School

Student's Legal Name: \_\_\_\_\_ Grade: \_\_\_\_\_  

Last Name
First Name
Middle Name

Residence: \_\_\_\_\_  

Street Address
City
State
Zip

Gender:  Male  Female Date of Birth: \_\_\_\_\_ City, State of Birth: \_\_\_\_\_ PA Entry Date: \_\_\_\_\_  

mm/dd/yyyy

mm/yyyy

School District Last Attended: \_\_\_\_\_ School Building: \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Grade: \_\_\_\_\_ 9<sup>th</sup> grade entry date: \_\_\_\_\_

Has your child previously attended South Middleton School District?  Yes  No  
 If "Yes", specify the last year the child attended South Middleton School District: \_\_\_\_\_ Grade: \_\_\_\_\_

The following information is required by the Pennsylvania Department of Education for child accounting purposes. Please be as accurate as possible.

If your child was born outside the U.S., specify the Country: \_\_\_\_\_ Initial U.S. Entry Date: \_\_\_\_\_

Years attending school in the U.S.: \_\_\_\_\_ Primary Language spoken in the home:  English  Other: \_\_\_\_\_

Your child's race:  Hispanic  Non Hispanic

Ethnicity: *(Please, check all ethnic groups that are appropriate):*  Caucasian  African American  
 American Indian/Alaskan Native  Asian  Native Hawaiian or other Pacific Islander  Multi-Racial

Are you placing any documents regarding custody on file with the School District?  Yes  No *(If yes, please attach)*

With whom does this child legally reside? *(check all that apply):*  Father  Mother  Other: *specify* \_\_\_\_\_

Marital status of the adults with whom the student resides *(please check one):*

Single  Married  Separated  Divorced  Widowed  Other: \_\_\_\_\_

In case of emergency, the first person contacted should be:  Father  Mother  Other: *specify* \_\_\_\_\_

CONTACT #1  Father  Mother  Step Father  Step Mother  Other \_\_\_\_\_

Title:  Mr.  Mrs.  Ms.  Miss  Other: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_

Residence: \_\_\_\_\_  

Street Address
City
State
Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

CONTACT #2  Father  Mother  Step Father  Step Mother  Other \_\_\_\_\_

Title:  Mr.  Mrs.  Ms.  Miss  Other: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_

Residence: \_\_\_\_\_  

Street Address
City
State
Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**CONTACT #3** (Optional)  Father  Mother  Step Father  Step Mother  Other \_\_\_\_\_

Title:  Mr.  Mrs.  Ms.  Miss  Other: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_

Residence: \_\_\_\_\_  
Street Address City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**CONTACT #4** (Optional)  Father  Mother  Step Father  Step Mother  Other \_\_\_\_\_

Title:  Mr.  Mrs.  Ms.  Miss  Other: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_

Residence: \_\_\_\_\_  
Street Address City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Sitter's Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Residence: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street Address City

Does your child have any health concerns, require medication, or require other physical accommodations?

Yes  No (If yes, please specify and/or attach records)

Does your child have an IEP?  Yes  No (If yes, check all that apply)

Learning Support  Life Skills  Emotional Support  Speech & Language  Gifted  Other \_\_\_\_\_

Does your child receive remedial services?  Yes  No (If yes, check all that apply)  Remedial Math  Remedial Reading

Does your child participate in an ESL/ELL program?  Yes  No

Has your child ever participated in an alternative education or juvenile detention program?  Yes  No

Is there an Internet-connected computer in your home that your child can use for homework?  Yes  No

**FOR OFFICE USE ONLY**

Student ID Number: \_\_\_\_\_ Homeroom/Teacher: \_\_\_\_\_

Entry Code: \_\_\_\_\_ Entry Date: \_\_\_\_\_

District Login: \_\_\_\_\_ Verification of Residency: \_\_\_\_\_

Bus #: \_\_\_\_\_ Bus Stop: \_\_\_\_\_

Please specify bus stop other than home address: \_\_\_\_\_

Sitter's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**SOUTH MIDDLETON**

4 Academy Street, Suite 100

Telephone 717-258-6484



**SCHOOL DISTRICT**

Boiling Springs, PA 17007

Facsimile 717-258-4667

**Health Survey**

Name: \_\_\_\_\_

Gender:     \_\_\_ Male \_\_\_ Female                      Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Please check if your child has any of the following conditions:**

- Arthritis/Rheumatic Disease
- Asthma
- ADHD
- Bleeding disorder/Cooley's Anemia
- Cardiovascular Condition
- Cerebral Palsy
- Cystic Fibrosis
- Diabetes: Type 1
- Diabetes: Type 2
- Life Threatening Allergy: food
- Life Threatening Allergy: other
- Seizure Disorder
- Sickle Cell Disease
- Spina Bifida
- Tourette's Syndrome

Please describe any chronic illness your child has \_\_\_\_\_

\_\_\_\_\_

Please describe any serious new illness, injury, or operation in the past year \_\_\_\_\_

\_\_\_\_\_

Other health concerns: \_\_\_\_\_

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Is your child presently taking medication? Yes No

	Name of Medication	Dosage	Reason	Duration of Time on Medication
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Should your child be restricted from participating in school sports or phys. ed.? Yes No  
If yes, please provide recommendations from your physician in writing.

Does your child have any allergies which require attention at school? Yes No

If yes, please list specific instructions for allergic reactions.

\_\_\_\_\_  
\_\_\_\_\_

Has your child recently traveled or lived outside of the United States?

Departure date: \_\_\_\_\_ Return date: \_\_\_\_\_

Countries visited: \_\_\_\_\_

Were there any changes in your family during the past year which might affect your Child's performance in school? Yes No

\_\_\_\_\_  
\_\_\_\_\_

Yes \_\_\_ I give permission for my child to receive a PA mandated physical exam by the school physician. (Applies only in grades K, 7, 11 as mandated by Department of Health)

No \_\_\_ My child will receive a physical by our private health care provider

Yes \_\_\_ I give permission for my child to receive a PA mandated dental exam by the school dentist. (Applies only in grades K, 3, 7 as mandated by Department of Health.)

No \_\_\_ My child will receive a dental exam by our private dentist

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



# HOME LANGUAGE SURVEY

**ALL newly registering students regardless of race, nationality, or language origin MUST complete this form.** Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

**Date:** \_\_\_\_\_

(Month) (Day) (Year)

**School Building (Check one):**

- W.G. Rice Elementary School
- Iron Forge Elementary School
- Yellow Breeches Middle School
- Boiling Springs High School

**Student Information (Parents/Guardians should complete this section):**

Child's first name: \_\_\_\_\_

Child's family name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_  
(Month/Day/Year)

**Questions for Parents or Guardians**

1. Is a language other than English spoken in the child's home?  No  Yes (language) \_\_\_\_\_
2. Does your child communicate in a language other than English?  No  Yes (language) \_\_\_\_\_
3. What is the language that your child first learned to speak? \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interpreter Provided  No  Yes

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**KINDERGARTEN REGISTRATION QUESTIONNAIRE**

Please complete this kindergarten registration questionnaire and bring it to registration.

Child's Legal name: \_\_\_\_\_ Nickname?: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Your child's household includes:

Mother \_\_\_\_\_ Father \_\_\_\_\_ Grandmother \_\_\_\_\_ Grandfather \_\_\_\_\_ Aunt \_\_\_\_\_ Uncle \_\_\_\_\_

Others (including babysitters or others who spend a significant amount of time with your child):

\_\_\_\_\_  
\_\_\_\_\_

Siblings:

Name	Age
_____	_____
_____	_____
_____	_____

Parents are: \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed

Is your child adopted? \_\_\_\_\_ if yes, does he/she know? \_\_\_\_\_

Did your child attend Pre-School? \_\_\_\_\_ No \_\_\_\_\_ Yes—which one? \_\_\_\_\_

List three of your child's favorite activities or interests:

\_\_\_\_\_  
\_\_\_\_\_

What does your child enjoy doing with the family?

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What is the biggest discipline problem you have with your child?

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What are your child's strengths?

---

What areas of growth do you see your child as needing?

---

How do you think your child will adjust to school?

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How does your child feel about starting kindergarten?

\_\_\_\_\_indifferent      \_\_\_\_\_excited      \_\_\_\_\_anxious

How do you feel about your child entering kindergarten?

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What else would you like us to know about your child so that we can help him/her have a good year in kindergarten?

---

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---

---

Signature

---

Relationship to child

---

Date

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# South Middleton School District Student Demographic Form

<b>Student Information</b>		
<b>Last Name:</b>	<b>Grade</b>	<b>Student Id Number</b> 000000
<b>First Name:</b>	<b>Hr</b>	<b>Birthday</b> / /

<b>Primary Parent/Guardian</b>	<b>Secondary Parent/Guardian</b>
Relationship to Student:	Relationship to Student:
<p>Please verify the information below. Make any changes to the Automated Notification System by changing the Yes/No status.</p>	
<b>Home Phone:</b>	<b>Home Phone:</b>
<b>Work Phone:</b> N/A	<b>Work Phone:</b> N/A
<b>Cell Phone:</b>	<b>Cell Phone:</b>
<b>Email:</b>	<b>Email:</b>
<b>Parent Place of Employment:</b>	<b>Parent Place of Employment:</b>
	<b>Would you like a mailing sent to this address?</b> _____

<b>Emergency Contact/Medical Information:</b>	
<b>Emergency Contact 1:</b>	
<b>Emergency Contact 2:</b>	
<b>Doctor:</b>	<b>Allergies</b>
<b>Dentist:</b>	<b>Permission to give the following medications:</b>
<b>Insurance:</b>	<b>Ibuprofen:</b> <b>Antacid:</b>
<b>Permission to Transport to Hospital:</b>	<b>Tylenol:</b> <b>Midol:</b>
<b>Preferred Hospital:</b>	<b>Asthma:</b> Y or N

Please review the demographic and health information listed above. If there are any changes, please make them to the right of the incorrect information.

I give permission for necessary information related to my child's condition to be shared with the school nurse.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Other information:** If there are any additional health or family concerns (unique health issues, custody arrangements, student restrictions, etc...) which you would like to inform the school, please provide that information on the back of this form or schedule a meeting with you child's principal, guidance counselor, or school nurse.

**PAGE 1 of 2 - PLEASE TURN OVER**



# South Middleton School District

## PHOTO/VIDEO RELEASE FORM

Dear Parent/Guardian,

With the many accomplishments of our students and staff, there are opportunities for South Middleton students involved in various school-related activities to be included in photographs and videotape footage. The photographs/videotape may be used in district publications, video productions, newspapers, the district web site, and on television.

In order to provide timely responses for requests to photograph or videotape our students, we are requesting that you indicate on the form below your desire regarding permission to have your child photographed/videotaped for use in publications, newspapers, video productions, or electronic media. This release form will remain in effect during your child's term of enrollment in the schools of South Middleton School District unless rescinded in writing.

If you have any questions, please contact your student's principal at 258-6484.

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### Permission to Participate in Media Events: News Releases, Photographs, Video Taping and Web Site Publishing

\_\_\_\_ I (We) GIVE permission to the South Middleton School District's schools to allow individual photographs or video tapes of my child to be used in publications, the news media, or productions.

\_\_\_\_ I (We) DO NOT give permission for individual photographs or videotapes of my child to be used in publications, the news media, or productions.

### Permission to Participate in Web Site Publishing

\_\_\_\_ Yes. My child's work may be placed on the South Middleton School District Website. I understand that no personal contact information, such as home address, phone number, or e-mail address, will be given. I understand that my child's work may be viewed by any person accessing the South Middleton School District website. Work will appear with a copyright notice prohibiting copying without my express written permission.

\_\_\_\_ No. My child's work MAY NOT be placed on the South Middleton School District website.

Student Name (Print): \_\_\_\_\_

School: \_\_\_\_\_ Grade/Room #: \_\_\_\_\_ / \_\_\_\_\_

Parent/Guardian (Print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PRIVATE PHYSICIAN'S REPORT OF  
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

DATE \_\_\_\_\_ 20\_\_\_\_

NAME OF SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ HOMEROOM \_\_\_\_\_

NAME OF CHILD			DATE OF BIRTH	SEX
_____	_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
Last	First	Middle		M F

ADDRESS

_____	_____	_____	_____	_____	_____
No. and Street	City or Post Office	Borough or Township	County	State	Zip Code

**MEDICAL HISTORY  
IMMUNIZATIONS AND TESTS**

VACCINE	Enter Month, Day, and Year each immunization was given			BOOSTERS & DATES	
	DOSES				
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD	1 / /	2 / /	3 / /	4 / /	5 / /
Polio (Circle): OPV, IPV	1 / /	2 / /	3 / /	4 / /	5 / /
Measles, Mumps, Rubella	1 / /	2 / /			
Hepatitis B	1 / /	2 / /	3 / /		
HIB	1 / /	2 / /	3 / /		
Varicella	1 / /	2 / /	Varicella Disease or Lab Evidence Date: _____		
Other: _____					

- MEDICAL EXEMPTION** The physical condition of the above named child is such that immunization would endanger life or health
- RELIGIOUS EXEMPTION** (Includes a strong moral or ethical conviction similar to a religious belief and requires a written statement from the parent/guardian)

**If Applicable:**

Tuberculin Tests Date Applied	Arm	Device	Antigen	Manufacturer	Signature
Date Read	Results (mm)		Signature		

Follow-Up of significant tuberculin tests:  
Parent/Guardian notified of significant findings on \_\_\_\_\_.

Result of Diagnostic Studies: \_\_\_\_\_  
Preventive Anti-Tuberculosis – Chemotherapy ordered.  No  Yes \_\_\_\_\_ Date \_\_\_\_\_

**Significant Medical Conditions (√)**

If Yes, Explain

	Yes	No	
Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemical Dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic Condition .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Illness .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education? If so, specify \_\_\_\_\_

**Report of Physical Examination (√)**

	Normal	Abnormal	Not Examined	Comments
▪ Height (inches)				
▪ Weight (pounds) BMI				
▪ Pulse ( )				
▪ Blood Pressure				
▪ Hair/Scalp				
▪ Skin				
▪ Eyes/Vision				
▪ Ears/Hearing				
▪ Nose and Throat				
▪ Teeth and Gingiva				
▪ Lymph Glands				
▪ Heart – Murmur, etc				
▪ Lung – Adventitious Finding				
▪ Abdomen				
▪ Genitourinary				
▪ Neuromuscular System				
▪ Extremities				
▪ Spine (Presence of Scoliosis)				

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Signature of Examiner

\_\_\_\_\_  
**PRINT** Name of Examiner

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

**PRIVATE DENTIST REPORT  
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE**

NAME OF SCHOOL \_\_\_\_\_ DATE \_\_\_\_\_ 20 \_\_\_\_

NAME OF CHILD  _____	AGE	SEX  <input type="checkbox"/> M <input type="checkbox"/> F	GRADE	SECTION/ROOM
_____ Last                      First                      Middle				

ADDRESS

\_\_\_\_\_

No. and Street	City or Post Office	Borough or Township	County	State	Zip
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**REPORT OF EXAMINATION**

	TOOTH CHART																
	RIGHT								LEFT								
	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	
UPPER																	Upper
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
UPPER																	Upper
LOWER																	Lower

Is The Child Under Treatment Yes  No

Treatment Completed Yes  No

\_\_\_\_\_ Date of Dental Examination

\_\_\_\_\_ Signature of Dental Examiner

\_\_\_\_\_ Print Name of Dental Examiner

\_\_\_\_\_ Address

# SOUTH MIDDLETON

4 Academy Street, Suite 100

Telephone 717-258-6484



# SCHOOL DISTRICT

Boiling Springs, PA 17007

Facsimile 717-258-4667

## ANNUAL FERPA NOTICE

A federal law called the Family Educational Rights and Privacy Act ("FERPA") gives parents of minor students and students who are eighteen years of age and older ("eligible students") certain rights with regard to the student's education records. Parents or eligible students have the following rights under FERPA:

1. The right to inspect and review the student's education records;
2. The right to seek amendment of the student's education records that the parent or eligible student believes to be inaccurate, misleading or otherwise in violation of the student's privacy rights;
3. The right to consent to disclosures of personally identifiable information contained in the student's education records except to the extent that FERPA authorizes disclosure without consent;
4. The right to refuse to allow the disclosure of certain "directory information" such as the student's name, address, telephone listing, e-mail address, photographs, date and place of birth, major fields of study, dates of attendance, grade level, participation in school activities and sports, height and weight of members of certain athletic teams, degrees, honors and awards received, and most recent previous educational agency or institution attended by student;
5. The right to file with the U.S. Department of Education a complaint concerning the alleged failures by the District to comply with the requirements of FERPA.

Parents or eligible students interested in inspecting and reviewing the student's education records should submit a written request to the school principal that identifies the records they wish to inspect. The principal will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

Parents or eligible students may ask South Middleton School District to amend a record that they believe is inaccurate or misleading by submitting a written request to the school principal clearly identifying the part of the record they want to be amended and specify how the record is inaccurate or misleading. The District will either amend the record as requested or notify the parents or eligible student of its decision not to amend the record. A parent or eligible student may appeal the District's decision not to amend the record and is entitled to a hearing regarding their request.

Parents and eligible students may file a complaint with the United States Department of Education concerning an alleged failure by the District to comply with FERPA requirements by contacting the Family Policy Compliance Office, U.S. Department of Education, 400 Maryland Avenue, SW, Washington D.C. 20202-4605.